Mount Sinai Genetic Testing Laboratory - Cytogenetics
and Cytogenomics Laboratory

AMNIOTIC FLUID INFORMED CONSENT AND RELEASE

I hereby request and authorize the Mount Sinai Genetic Testing Laboratory of the Department of Genetics and Genomic Sciences to make personal determination of the chromosome constitution and/or biochemical and/or DNA status of my unborn fetus. It has been explained to me and I understand that:

1. The procedure of amniocentesis involves a small, but unknown risk to the mother and the fetus.
2. There is the possibility that the cell culture of the chromosome and/or biochemical and/or DNA analyses may not accurately reflect the status of the fetus.
3. It is possible that the results of the chromosome and/or biochemical and or DNA analyses may not accurately reflect the status of the fetus.
4. More than one amniocentesis may be necessary.
5. The finding of a normal chromosome constitution or biochemical/DNA status does not eliminate the possibility that the child may have birth defects and/or mental retardation.
6. No test will be performed on my sample other than the one(s) authorized by my doctor.
7. I give consent to have my specimen be used anonymously by the laboratory for the purposes of quality control or for research related to genetic disease. Please check the box below to consent. If you do not consent your sample will be discarded within 2 months of completion of the testing.

☐ I agree to have my sample used anonymously for research by the laboratory. ______

initials

8. The nature of chromosome and/or biochemical and or DNA analyses has been explained to me and the accuracy of the test and its limitations have been detailed. I understand that while results obtained from this testing are usually highly accurate, infrequent errors may occur.

9. I understand that this testing may yield results that are of unknown clinical significance and that parental blood samples may be also be tested to determine whether a specific finding was inherited.

10. The results of my test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a clinical geneticist.

11. I have had the opportunity to have all of my questions answered and undertake professional genetic counseling prior to signing the form. I understand that this consent is being obtained in
order to protect my right to have all of my questions answered before testing. I also understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

This amniocentesis is being performed for the following reasons:
1. To rule out a chromosome defect in the fetus.
2. To rule out an open neural tube in the fetus.
3. ________________________________.

I understand that the results of these studies will be reported directly to my obstetrician.

I understand that at some time in the future, the Mount Sinai Genetic Testing Laboratory or their associates of the Department of Genetics and Genomic Sciences may wish to contact me for information about the baby or my experience at Mount Sinai with prenatal diagnosis.

______________________  ______________________
(WITNESS)               (SIGNATURE)

______________________  ______________________
(DATE)                  (PRINT NAME)

(rev.09/07/2011)